MGA Health Clinic

Middle Georgia State University

Macon Campus, Community Education Center:	**Cochran Campus, Browning Hall:**
100 University Parkway Macon, GA 31206	1100 Second Street SE Cochran, GA 31014
Phone 478-471-2092 / Fax 478-471-2779	Phone 478-271-5401 / Fax 478-271-0347

Medical Records Release Form

Patient Name:			
Street Address:		**Apt #:**	
City:	**State:**	**Zip:**	
Phone:	**DOB:**	**Macon State College ID#** _____-_____-_____	

I authorize release from: (name of disclosing party)		**To release to:** (name of receiving party)	
Name:		**Name:**	
Address:		**Address:**	
City:		**City:**	
State:	**Zip:**	**State:**	**Zip:**
Phone:	**Fax:**	**Phone:**	**Fax:**

Please check box below for specific information to be released:

☐ General medical records (includes lab results, provider notes, etc) Signature: _____ Date: _____

☐ Immunization records Signature: _____ Date: _____

☐ Drug/Alcohol records Signature: _____ Date: _____

☐ HIV test results Signature: _____ Date: _____

☐ Other (Specify): _____

Signature: _____ Date: _____

Please:	**The purpose of this release is for:**
☐ Mail the records	☐ Continuity of care
☐ Fax the records	☐ Other: _____
☐ I will pick up the records	

My consent may be revoked at any time. Unless previously revoked, this consent will terminate six (6) months after the date of my signing this consent. Each disclosure requires an additional signed authorization.

Signature of Patient:_____ Date: _____